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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 23 1941

Registration District No. 257

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26386

Primary Registration District No. 6099

Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard Castor Twp
(b) City or town ~~Bloomfield~~, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 1 year & 15 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Stoddard 103
(c) City or town Bloomfield, Rural 0
(If outside city or town limits, write "RURAL") 8
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME BERT LEON CHRISTIAN

3. (b) If veteran, name war ----

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 15, 1940 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
1	--	15	hr. min.

9. Birthplace Bloomfield, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Bert Christian

13. Birthplace Essex, Mo. (City, town, or county) (State or foreign country)

14. Maiden name Lulu Neal

15. Birthplace Bloomfield, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Bert Christian
(b) Address Bloomfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 41 (Month) (Day) (Year)
(c) Place: burial or cremation Triplett cemetery

18. (a) Signature of funeral director Chiles Und. Co.
(b) Address Bloomfield, Mo.

19. (a) July 26'41 (Date received local registrar) (b) Leonid Tunch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th
year 1941 hour 5:45 minute P. M.

21. I hereby certify that I attended the deceased from June 29, 1941, to June 30, 1941
that I last saw him alive on June 30, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
ACUTE CIRCULATORY FAILURE	
Due to KEROSENE POISONING	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature D L Davis (M. D. or other)
Address Bloomfield Mo Date signed

070 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 841 1112
Date Filed 8-15-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Isaac Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26386

Registration District No. 837 Primary Registration District No. 6099 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Bloomfield Mo.

1. PLACE OF DEATH

(a) County Stoddard

(b) City or town Bloomfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Bert L. Christian

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Oct. 1, '41 (Date received local registrar) (b) Leonard Burch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 30 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute circulatory failure	
Due to Kerosene poisoning	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

179X 13

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT

(b) Date of occurrence JUNE 29, 1941

(c) Where did injury occur? CASTOR TWP. (City or town) STODDARD (County) MO (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? HOME (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY